

Adoption & Attachment Treatment Center of Iowa

A subsidiary of Best Growth Options Counseling Service, Inc.

800 Webster Street Iowa City, Iowa 52240

Fax: (319) 338-7758 Ph: (319) 338-2722

Intake Assessment Form

Information Provided by _____ Relationship to child: _____ Date: _____

We are proud to be an Accredited Chapter 24 Mental Health Clinic by the State of Iowa. To maintain this level of accreditation, we have to obtain the information required below. Therefore, it is VERY important for you to fill out this form **completely!** Clearly, this will also give us the full picture of the child's past and present to better be able to accurately diagnose, and more effectively treat your child.

1) Information for child seeking treatment:

_____	_____	_____	_____	_____
First name	Middle Initial	Last name	DOB	Age
_____	_____	_____	_____	_____
Social Security Number	Nationality/Ethnicity	Male	Female	Circle Gender

2) Parents full names and DOB:

Parent #1 _____	DOB _____	SS# (for insurance filing) _____
Parent #2 _____	DOB _____	SS# (for insurance filing) _____

3) Home Address:

_____	_____	_____	_____
Street	City	State	Zip code

4) Telephone:

_____	_____	_____	_____	_____
Daytime	Evening	Mom	Cell(s)	Dad

5) Child's School Name: _____ School Phone #:(____)_____

_____	_____	_____	_____
Street	City	State	Zip code

Grade _____	Teacher _____	Counselor _____	Principal _____
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6) Special Education/Resources/AEA/IEP? (Please list Teachers & all Services) _____

7) Other people residing in the family home:

Name
Gender
Birth Date
Age
School/Grade

Name
Gender
Birth Date
Age
School/Grade

Name
Gender
Birth Date
Age
School/Grade

Name
Gender
Birth Date
Age
School/Grade

8) Parents Information:

Parent #1 Occupation & Employed by _____

Business Telephone _____

Parent #2 Occupation & Employed by _____

Business Telephone _____

Parent's Levels of Education: Parent #1 _____ Parent #2 _____

9) Child's Physician's Name _____ Clinic _____

_____ (____) _____
Street City State Zip Code Area Code Phone

10) Child's Psychiatrist's Name _____ Clinic _____

_____ (____) _____
Street City State Zip Code Area Code Phone

11) To assure that you/your child's Psychiatric needs (medication) are being met, please check one of the following:
 Need Psychiatry referral Satisfied with current Psychiatrist NO need for Psychiatrist

12) Child's Current Medications & Dosages:

_____ mgs Time(s) Taken: _____ Date prescription initially started: _____

_____ mgs Time(s) Taken: _____ Date prescription initially started: _____

_____ mgs Time(s) Taken: _____ Date prescription initially started: _____

_____ mgs Time(s) Taken: _____ Date prescription initially started: _____

13) List any Problematic Side Effects:

14) Is the Medication working?

If on a medication regime, is the patient compliant? _____yes or _____no

15) Please list ALL health concerns regarding your child:

PAST:

PRESENT:

16) Please list ALL allergies, adverse reactions/sensitivities to foods, drugs, & other substances the child may have:

17) Referral source & referral source telephone number: If we need to stay in contact with them.

____Friend ____Other client (no name) ____Phone Ad ____Website ____Therapist
____DHS ____Physician ____Psychiatrist ____School ____Adoption Agency ____Presentation

18) What event(s) prompted you to you seek treatment **at this time**?

19) Risk Factors: Please check ALL that Apply:

____ Non compliance with treatment _____ AMA/elopement potential
____ Prior behavioral health inpatient admissions _____ Substance Abuse
____ Number of multiple behavioral diagnosis _____ Suicidal/Homicidal ideation
____ Immediate risk of harm to self _____ Immediate risk of harm to adults
____ Immediate risk of harm to animals _____ Immediate risk of harm to small children
____ Other, Please Explain: _____

20) List additional family stressors or concerns at this time (Mental, Physical, Emotional Health of other family members, employment, housing, financial, recent losses, etc.):

21) Substance Abuse (for child entering treatment)

Note: if parent has challenges, please indicate this, as well

Does the Child use and/or abuse Nicotine _____No _____Yes, Amount per day _____
Does the Child use and/or abuse Caffeine _____No _____Yes, Amount per day _____
Does the Child abuse Non-Prescription Medications: _____No _____Yes, Amount per day _____
What age began using illicit drug (Type) _____ at age _____ Frequency _____ per _____
What age began using Alcohol _____ (Type) _____ Frequency _____ per _____
Date & Type of Treatment participated in _____ through _____
Length of current relapse, if applicable _____
Relapse prevention plan/sobriety plan _____

Areas of stress (e.g. family, work, church, friends, etc.) that trigger using substance _____

Areas of support (e.g. family, work, church, friends, AA, NA, etc.) that have been helpful _____

21) Describe each parent's relationship with each child in treatment:

Parent #1:

Parent #2:

22) What changes would you like to see in your child?

Yourself?

And in your family?

23) Is child adopted? If yes, from where?

24) What age was the child placed in adoptive home?

25) Child's first name, prior to adoption?

26) What has the child been told regarding the adoption?

27) List any known Complications of Pregnancy, Birth & Delivery:

28) Are there any problem areas or areas you feel the child is/was advanced or slow in development?

29) Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life?

30) Is there, as far as you know, any possible history that could be considered abusive or neglectful? If so, indicate type(s) and age of occurrence:

31) Explain child's history of placements prior to placement in your home:

32) List all previous diagnosis given:

33) Describe Previous Testing/Treatment or Therapy Experiences:

Please include complete address in case we may need to collaborate with them (start with earliest):

Dates _____ to _____ Agency/Professional's Name _____

_____ (_____) _____
Street City State Zip code Area Code Phone
Outcome/Response to Treatment _____

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For Clinicians Only

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF _____ Highest in last year _____ Expected at Discharge _____

Coordination of Care:

Need to contact

Physician _____

Yes No

Psychiatrist _____

Yes No

OT/SI/SPU _____

Yes No

DHS Worker _____

Yes No

Case Manager _____

Yes No

Others: ___Family___ Caregivers/Sitters___ Teacher___

Yes No

Treatment /Goal Planning

Initial Focus 3-6 months

Secondary Focus 6-12 months

Therapist of Intake/Assessment _____ Date _____
(revised 10-20-06)

